STATE OF FLORIDA

AGENCY FOR HEALTH CARE ADMINISTRATION

December 15, 1997

Ms. Alisa Adamo
Project Officer
Department of Hea th & Human Services
Health Care Financing Administration
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms. Adamo:

Attached please find Florida's responses to the questions posed by HCFA concerning the State's proposal for a family planning demonstration project under section 1115 of the Social Security Act. We appreciate the time and effort staff from the Center for Medicaid and State Operations and the Regional office have spent on Florida's proposal.

We look forward to working with you as we develop this very important program for Florida. If you require additional information, please let us know. The contact person for this waiver is Gail Vail, ACHA Administrator, (850) 922-7329.

Sincerely,

/s/

for Richard T. Lutz, Director
Division of State Health Purchasing

Attachments

MEDICAID ADMINISTRATION
P.O. BOX 13000 • TALLAHASSEE, FLORIDA 32317-3000

LAWTON CHILES, GOVERNOR

Florida Medicaid — Responses to HCFA Issues

Provider Access and Outreach

1. Please discuss whether there are currently a sufficient number of family planning providers participating in Medicaid to meet the needs of the target population.

Currently a total of 67,036 Medicaid recipients receive family planning services and we anticipate they will continue to receive these services. Of this population, we project that about 12,000 patients each year will be eligible to receive extended family planning services. Recipients targeted to receive waiver services are not new Medicaid recipients. They are presently receiving family planning services during their postpartum period. This waiver will allow a two-year extension of services already being rendered by existing Medicaid providers.

In most cases the provider who supervised the woman during her prenatal period and was responsible for her prenatal and post-natal care will also provide her family planning services.

Florida Medicaid is confident there is a sufficient number **of** enrolled family planning providers in addition to its extensive Medipass provider network. For example, the 67 County Health Departments have over 200 satellite clinics located throughout Florida. There are 95 Federally Qualified Health Centers located in areas of medically underserved populations and 116 Rural Health clinics in designated areas. All of these providers are qualified to provide family planning services to Medicaid patients.

2. Are there any providers from whom a Medicaid eligible could receive family planning services, but from whom a waiver eligible could not?

Waiver participants will be able to receive family planning services from all providers except those who are members of an **HMO** and who do not have a separate Medicaid provider number (fee-for-service or Medipass). See our response to question 3 for additional information.

3. For women who were previously enrolled in managed care, would they still be enrolled in the managed care organization for a limited benefits package? If not, could they still receive services from their managed care provider? Would the MCO be paid on a capitated or fee-for-service basis?

Every attempt will be made to ensure continuity of care for participants in this project. Women enrolled under the waiver will not be candidates for managed care. However, they may continue to receive the extended family planning services from their same health care provider on a fee-for-service basis. An exception may occur when a recipient's current HMO provider does not bill Medicaid fee-for-service.

Each recipient will receive an announcement regarding the services to be offered and that they can easily obtain these expanded services fi-om any of the county health departments. These recipients will be able to choose from a list of available Medicaid fee-for-service providers if they choose not to seek services from the county health departments.

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4. Please provide more information on what strategies you will be using to get women to use family planning services.

The Florida Agency for Health Care Administration (AHCA) and the state Department of Health (DOH) will work jointly to build on existing public awareness efforts to promote family planning services. Collaboration with other involved agencies and programs will occur through the mechanism of a Public Awareness Task Force. In addition to AHCA and DOH representation, task members will include: consumers; the Florida Hospital Association; Florida Healthy Start Coalition; the Florida Department of Children and Families, including Welfare Reform; local County Health Departments and Planned Parenthood Organizations; Medicaid providers; the Florida Developmental Disabilities Council (DDC) and others involved in family planning services throughout the state. The idea behind forming the task force is to'facilitate the support and collaboration of other involved agencies and programs in promoting family planning services.

The Public Awareness Task Force will serve as the guiding force in the further refinement and development of the public awareness activities listed in the compendium of public awareness activities, which is included as Appendix 2 in the Medicaid Waiver Application. DOH and AHCA will contract with the Lawton and Rhea Chiles Center at the University of South Florida College of Public Health (USF COPH) to coordinate the task force organization and meetings. USF COPH will produce a *summary* report of task force recommendations, which will be presented to DOH and AHCA within the first two months of the project.

All products and materials produced will build on the public awareness activities of the Help Them Thrive Birth-to-Five campaign (see attached packet of promotional materials). This was a statewide social marketing campaign that began with an extensive

qualitative and quantitative social marketing research component with consumers and providers. Some of the resulting brochures were targeted to reach women in need of family planning services. Colorful and ethnically diverse brochures in English and Spanish have been developed which address condoms, baby spacing, and birth control pills. For consistency, brochures with a similar appearance will be developed and included in the packets. The new brochure will be in Spanish and English and will address the extended family planning services available through the Medicaid waiver.

The Medicaid Management Information System will be coded to generate notices to recipient women who are losing their Medicaid eligibility. These women will then receive a notice explaining they are no longer eligible for Medicaid but can continue to receive Medicaid coverage for family planning services. The notice will contain a simple explanation of family planning services.

During the Help Them Thrive Birth-to-Five public awareness and consumer education campaign, some communities used family planning PSAs, outdoor billboards, public transit signs, and newspaper advertising. PSAs are available addressing family planning issues ("MTV Girl" & "Baby Spacing"). These existing PSAs could be modified to include new information about the availability of the Medicaid Waiver. They reflect the cultural diversity of the state and are targeted to eligible consumers. It is also anticipated that new promotional materials to be developed will specifically address the availability of family planning Medicaid Waiver services.

USF COPH will also be contracted with to produce a video teleconference to train DOH and AHCA staff as well as Medicaid and other family planning providers about family planning services and the availability of the Medicaid waiver. The video teleconference will be taped and widely distributed throughout the state. DOH and AHCA staff will conduct presentations on family planning and the Medicaid Waiver at conferences and statewide meetings. It is anticipated that speakers and speakers bureaus will evolve from the DOH and AHCA staff and the Public Awareness Task Force to further promote the family planning Medicaid Waiver. Front-line staff and provider awareness of family planning and Medicaid Waiver services are a key component in getting eligible women to utilize these services.

Public awareness activities, including products and promotional activities will be completed within the first year of Waiver implementation. The contract with USF COPH will be for a period of ten months with contractual timelines for the completion and production of all activities, products and promotional materials. The products and promotional materials such as videos, brochures, and posters, will be available for distribution throughout the waiver approval period. AHCA and DOH, will provide on-going professional development.

5. Please submit copies of the promotional materials that were used for the "Help Them Thrive Birth-to-Five Campaign."

Enclosed

Quality/Oversight

6. Please clarify what quality standards will be used for the program. What type of oversight will the State have over this program?

Since the proposed waiver is an extension of services already being provided by the Florida Medicaid Program, the same HCFA approved quality assurance methods and oversight will be used with waiver services. These methods are described below:

Office of the Inspector General

The Office of the Inspector General (OIG) ensures the accountability, integrity, and efficiency of AHCA programs through internal audits, investigations, and evaluations.

Peer Review Organization

The Florida Medicaid program requires the Peer Review Organization (PRO) to conduct periodic medical record reviews to ensure that County Health Departments (CHD), Federally Qualified Health Centers (FQHC) Rural Health Clinics (RHC), Medipass physicians, Health Maintenance Organizations (HMO), and other providers furnish quality, medically necessary, and accessible health care to Florida Medicaid recipients.

The PRO is responsible for reviewing a minimum of 1,000 clinic records (includes the three clinic types), a minimum of 500 outpatient hospital medical record reviews, 6,000 Medipass medical records, and 7,500 reviews of HMO medical records.

AHCA provides the PRO computer tapes, and they are responsible for running the sample according to guidelines issued by Florida Medicaid. Please see Attachment A for copies of the family planning assessment tools used by the PRO.

Medicaid Program Integrity

By monitoring Medicaid data and following up on complaints, Medicaid Program Integrity staff identifies Medicaid providers and recipients who may be abusing the program. After a full investigation, the unit may recover funds that have been misused or refer a case to law enforcement for further action.

The Division Health Quality Assurance

The Division of Health Quality Assurance (HQA) regulates and monitors the quality of the state's licensed health care facilities. Through the following five bureaus the Agency is able to regulate managed care providers, direct state licensure and federal certification of facilities and services, investigate consumer complaints regarding facilities, services, and practitioners, and provide training to facilities to continuously improve quality of care.

Health Facility Regulation - (HFR) is the bureau responsible for the statewide management of Florida licensure and federal Medicare/Medicaid certification programs. In addition, HFR manages the federal Clinical Laboratory Improvement Amendment (CLIA) certification program for Florida's laboratories.

Managed Health Care - This bureau's duty is to ensure that quality health care services are provided by all managed care organizations regardless of payer source.

Medical Quality Assurance - MQA develops policies that allow AHCA to effectively regulate medical professionals. Its primary goal is to protect the health and safety of Floridians.

Field Operations - Field Operations directs facility inspections, which evaluate factors such as management and administration, nursing services, social services and laboratory services. In addition, it helps to develop facility regulations and procedures, investigates complaints about facilities, and carries out certain quality assurance initiatives. Field Operations has eleven area offices that offer facility quality assurance services to Florida's **67** counties.

Office of Plans and Construction - This office is primarily responsible for reviewing and approving the structural integrity of health care facilities to ensure patients' safety.

HQA works with numerous community organizations, such as professional facility and practitioner associations, and other public and private agencies. It is also involved in provider education and training, and participates in local forums to inform providers of AHCA's strategies for reform and quality assurance.

Confidentiality

7. Please discuss how confidentiality of all program participants, including adolescents, will be maintained.

The confidentiality of recipients of family planning waiver services will be maintained as it is for all other Medicaid services. Florida's Medicaid Provider Reimbursement Handbook states that all information about Medicaid recipients is confidential under federal law. Information cannot be released without the patient's written consent unless the provider is billing a third party or releasing the information to a billing agent. Billing agents must adhere to all federal and state confidentiality requirements.

The State places restrictions on the release of any information about ***AIDS*** testing **and** treatment, and sexually transmitted diseases **(STD). A** signed release must state what specific information the patient is giving permission to release. General medical releases are not allowed. **A** parent or guardian cannot be informed of the dependent's medical care related to ***AIDS*** or **STD** without the dependent's written permission. This information is also contained in the Florida Medicaid Provider Reimbursement Handbook.

8. Are there provisions in place to ensure that services provided to minors are not incorrectly limited to only those minors who have the consent of their parent or guardian?

Yes. Florida has provisions in place that do not limit family planning services to only minors having the consent of a parent or guardian. This policy is applicable to all Medicaid services and practitioners providing family planning services.

Phase-Out

9. The State will have to develop a phase-out plan for the demonstration.

Florida plans to continue enrolling new participants in the waiver program throughout the five years. The recipient letter that will be sent to all participants in the family planning waiver will inform them of their eligibility for two years of extended family planning services. At the end of the third year of the project, the letter being sent to new participants will be modified informing recipients of their eligibility for family planning services until the end date of the project.

However, throughout the project we will be evaluating recipient participation in the demonstration waiver and will pursue the possibility of extending the waiver beyond the proposed five years. If an extension of this demonstration is granted, the recipient letter will again be modified to inform recipients of their eligibility for two years of extended family planning services.

Grievances

10. Please provide information on the process that will be used for handling complaints and grievances of program participants.

Participants in the extended family planning services program will have access to the same grievance procedures presently used by the Florida Medicaid Program.

A brochure sent with all Medicaid ID cards provides the recipient with "hotline" phone numbers to report complaints. This brochure contains a telephone number for complaints against health care practitioners and a number for complaints against HMOs.

Once a call is received by Medical Quality Assurance Consumer services, a determination is made of whether the complaint warrants an investigation. The Managed Health Care Bureau of the Division of Health Quality Assurance performs investigations of quality of care complaints involving managed care organizations. This bureau also manages the Statewide Provider and Subscriber Assistance Panel which hears consumer and plan grievances, mediates, and troubleshoots.

Evaluation of the Project

11. Please describe the data sources that will be used for the evaluation of the program.

Hypotheses 1, 2, 3, and 4 will use the Florida Medicaid Management Information System as a data source in the evaluation of this waiver. FMMIS is a General Systems Design (GSD) compliant system used by the state of Florida for the payment of Medicaid claims. The system consists primarily of a claims history file, an eligibility system and a reference system. The claims history file includes all claims submitted to the state for reimbursement under the Medicaid Program. All claims for physician services, hospitalizations, prescription drugs and all other components of the Medicaid Program reside in the history file. The eligibility system includes entries for each person eligible for Medicaid services. This system provides information on the periods and categories of eligibility as well as demographic data related to individuals eligible for Medicaid.

The reference system includes data on payment rates for various Medicaid covered services. Physician fees, hospital reimbursement rates, and drug pricing information are among the components of this system.

Hypotheses *6* and 7 use as their data source the Florida Department of Health Vital Statistics. These data are compiled fiom the original records that were filed with the Office of Vital Statistics (VS) as required by state law. These include records of live births, deaths, fetal deaths, marriages, and dissolution of marriage. Standard forms recommended by the U.S. Public Health Conference on Records and Statistics are for the most part used for certificates of live birth, death and fetal death.

Responsibility for filing birth certificates lies with the physician, midwife or other attendant. Funeral directors, or other persons acting as such, are legally charged with filing death and fetal death **(20** or more week's gestation) certificates. These certificates are then submitted to local registrars who in turn forward them to VS. VS receives marriage and dissolution records directly from the various courts.

In Florida, **VS** links infant birth and death certificates. Birth certificate data includes demographic information, information specific to the birth and delivery, such as, place of birth, complications during delivery, and infant specific information such as, birth weight, and congenital anomalies. Death certificate data contains demographic information and cause of death, including unknown causes.

12. Please discuss how the impact of this program will be isolated from other activities occurring in the State (e.g., welfare reform, teen pregnancy initiatives, etc.).

It would be difficult to isolate the impact of this program fiom other activities occurring in the state such as welfare reform and teen pregnancy initiatives. However, every effort will be made in the ongoing evaluation of all program components to incorporate qualitative research methods. Qualitative assessment questionnaires will be implemented and directed to both consumers and providers to enable evaluators to ascertain program effectiveness.

13. Please provide more justification as to why the University of South Florida, College of Public Health, Lawton and Rhea Chiles Center is the most appropriate entity to evaluate this project. Why are other evaluators not being sought out through a competitive bid process?

The University of South Florida, College of Public Health, Lawton and Rhea Chiles Center was selected for the evaluation because they already have data files that will be

needed to conduct the evaluation. USF has an ongoing contract to provide AHCA with outcome measures related to pregnancy services. USF merges birth certificate data with Medicaid eligibility; Women, Infants and Children Nutrition services (WIC), and Healthy Start data, and can provide information on birth outcomes by provider over a period of years. USF was the group that calculated the current average interpregnancy interval for Medicaid recipients. This multi-year data set will allow them to track individuals over several years with minimal investment. Development of this data set cost a considerable amount of effort and **AHCA** wishes to obtain a return on this investment. Use **of** this contractor frees revenue for the proposed qualitative work to determine the approaches most likely to result in recipients accessing services.

Budget Neutrality

We have prepared the budget neutrality section using the model worksheet provided. See Attachment B. Please note that the cost of a delivery and the first year costs will be the same with the waiver or without the waiver.

The correct amounts were entered on the worksheets for systems changes, public awareness, and evaluation. System changes are expected to be first year costs only. Although public awareness will continue throughout the project, costs are expected to be realized during the first year.

Assumptions

14. **The state has a very high estimate of the current fertility rate for the expansion population. It has used a rate of 27%, while national statistics for women with incomes under $10,000 is 8.9%. The average fertility rate in the U.S. is 6.47%. Please explain why Florida believes the fertility rate of the expansion populations are so much higher.**

65.7 / 1000 the US

Fertility rate is defined by the Centers for Disease Control and Prevention as births per 1,000 women ages 15-44. **Our** target population falls within this age group but is known to be fertile since they have just completed a pregnancy. In addition, those women who have had a sterilization procedure are excluded fiom our target population. Because women who may be infertile or who have had a sterilization are not excluded when calculating the average **U.S.** fertility rate, the rate for our target population is expected to be higher. In fact, Florida's Resource Mother study of only second births had a rate comparable to the one we used. The Resource Mother program is funded under a current section 1115 waiver to prevent second pregnancies for women giving birth under Medicaid in the Gainesville area. The rate of pregnancy for those in the control group

proportion who become pregnant in the absence of

who dropped out of tracking was 27.4%. The rate of pregnancy was 7.1% for those receiving services who stayed in the program.

The methodology used in preparing this section was based on a 1995 Florida report, ***"Pregnancies Averted in Publicly-Funded Family Planning Users"*** (See Attachment C). According to Forrest and Singh (1990), there are four different patterns of behavior and expected fecundity (e.g., the physiological ability to reproduce) for women eligible for subsidized family planning care who are at risk of unintended pregnancy. See Table 1.

Table 1

Pattern	*Description*	*Expected Fecundity*	*#Pregnancies Avoided with Family Planning*
IV	Women using no formal contraceptive method.	78%	92%
III	New family planning clients before accessing family planning clinic care.	47%	88%
II	Women who discontinue oral contraceptive use and do not switch to another prescription method	33%	83%
I	Women who do not use publicly-funded contraceptive services but do use other services.	27%	79%

In the 1995 report, these four patterns were applied to the total number (157,887) of 1994 Title X-funded users in Florida. For example, if all of the 157,887 users were categorized **as** having Pattern I behavior, the number **of** pregnancies that would result is 42,629 (157,887 X 0.27). With participation in the family planning program, Pattern I users would avoid 33,678 (42,629 X 0.79) pregnancies. These data come fi-om Table XIII, p. 13 of Attachment C.

As a method of calculating possible averted pregnancies with the proposed expansion of family planning services, we applied the Pattern I behavior to the target population. We used Pattern I because of the lower expected fecundity and because the 27% was consistent with findings fiom the control group for the Resource Mother program.

As we are confident that the proposed expansion of family planning services will demonstrate budget neutrality, we have recalculated the budget section using the **6.47% U.S.** average fertility rate mentioned in your letter and a study completed **by** Tompkins, **(1986)'** that contains a methodology for estimating averted pregnancies. Tompkins' method of estimating averted pregnancies was used in section **1115** waivers submitted by the states of Arkansas and South Carolina. According to Tompkins, for every **15** women who seek family planning services one birth will be averted. The result of this recalculation indicates a Medicaid savings of **$7,813,925.** See Attachment D.

[1] Tompkins, Mark E. (1986). *The Impact of Family Planning Services in South Carolina,* (report submitted to the S.C. Department of Health and Environmental Control). 34 pp.

ATTACHMENTS

ATTACHMENT A

C

FAMILY PLANNING
ANNUAL EXAMINATION
PROCEDURE CODES: W9759 and W9840

Provider ID:_____ Provider:_____ Svc Dt:_____

Medicaid #:_____ _____ Rv Dt:_____

PATIENT'S NAME: Last, First, MI

RC #:_____

SUBJECTIVE DATA

A. INITIAL EXAMINATION:

1. SUBJECTIVE DATA CONTAINS:

- Y N Complete OB history?
- Y N Complete GYN history?
- Y N Complete Medical history?
- Y N Complete Surgical history?
- Y N Previous Contraceptive history?
- Y N Previous GYN conditions?
- Y N Sexual Activity history?
- Y N STD history?
- Y N HIV Risk Assessment?

B. ANNUAL EXAMINATION

- Y N Subjective data updates as appropriate?

OBJECTIVE DATA

OBJECTIVE DATA CONTAINS:

- Y N Height & Weight?
- Y N Blood Pressure?

COMPLETE PHYSICAL INCLUDING:

- Y N Thyroid Palpation?
- Y N Auscultation of heart and lungs?
- Y N Pelvic exam including cervical visualization, bimanual and recto-vaginal (for females)?
- Y N Breast & axilla exam accompanied by self-exam instructions?
- Y N Abdominal exam and liver palpation?

LABORATORY DATA:

- Y N Pap Smear obtained and results recorded?
- Y N Hemoglobin / Hematocrit results recorded?
- Y N N/A Urinalysis as indicated?
- Y N N/A Rubella titre, as indicated, and recorded?
- Y N **VDRL results recorded?
- Y N **Chlamydia culture results recorded?
- Y N **Gonorrhea culture results recorded?

**Note: Not required by Medicaid but as indicated by Physicians. Refer to Matrix in audio tele-conference 9/94.

ASSESSMENT

1. Y N Practitioner provided a diagnosis?
2. Y N Practitioner's diagnosis consistent with subjective & Objective data?

PLAN

1. TREATMENT/INTERVENTIONS:

- Y N N/A Family planning method prescribed as appropriate for the assessment?
- Y N N/A Practitioner's treatment/interventions consistent with accepted practice parameters?

2. EDUCATION/COUNSELING:

- Y N N/A Documentation of appropriate Braided education/counseling for chosen method of birth control?
- Y N N/A Record contain a signed and witnessed informed consent form?

SERVICE

- Y N Appropriate Level Personnel Providing Service? MD DO PA RN ARNP OTHER (check one)
- Y N Florida Professional Licenses in Employee File?
- Y N N/A Require Standard of Care Protocol?
- Y N N/A Service Rendered by Credentialed Nurse?
- Y N N/A Credentialling proof in provider's Emp File?
- Y N Medically Necessary?

DOCUMENTATION

- Y N Practitioner dated each record entry?
- Y N Each Record Entry Legibly signed?
- Y N Service recorded on appropriate standardized form?

FAMILY PLANNING COUNSELING VISIT PROCEDURE CODE: W9850

Provider ID:_____ Provider:_____ Svc Dt:_____

Medicaid #:_____ _____ Rv Dt:_____

(PATIENT'S NAME: Last, First, MI)

RC #:_____

SUBJECTIVE DATA

Y | N Information obtained regarding family planning, reproduction physiology, chosen method of birth control, side or untoward effects of the family planning method, infertility, and/or planned pregnancy?

OBJECTIVE DATA

RECORD HAVE DOCUMENTATION OF RECIPIENT'S:

Y | N | N/A Pertinent lab data based on client's chief complaint or other data?

ASSESSMENT

1. Y | N | N/A Examiner identified all pertinent problems?
2. Y | N Examiner **made** appropriate family planning recommendations?

PLAN

TREATMENT/INTERVENTIONS:

Y | N Family planning method been individualized?

EDUCATION/COUNSELING:

Y | N | N/A Recipient received specific Braided counseling as indicated by the method?

CONSULTATION/REFERRAL

Y | N | N/A Recipient referred to appropriate specialist?

FOLLOW-UP

Y | N | N/A Adequate follow-up documented?

SERVICE

Y | N Appropriate Level Personnel Providing Service?

MD | PA | RN | ARNP | OTHER (check one)

Y | N Florida Professional License in Employee File?

Y | N | N/A Require Standard of Care Protocol?

Y | N | N/A Service Rendered by Credentialed Nurse?

Y | N | N/A Credentialling proof in provider's Emp File?

Y | N Medically Necessary?

DOCUMENTATION

Y | N Practitioner dated each record entry?

Y | N Each Record Entry Legibly signed?

Y | N Service recorded on appropriate standardized form?

E

FAMILY PLANNING

Provider ID:_____ Provider:_____ Svc Dt:_____

_____ _____ _____ _____ _____

RC #: _____

SUBJECTIVE DATA

Y N Side Effects of Medications?

OBJECTIVE DATA

RECORD HAVE DOCUMENTATION OF RECIPIENT'S:

Y N Lab as indicated? Y N **Blood** Pressure?

Y N Weight

ASSESSMENT

Y N Family Planning Recommendations?

Y N Identification of Problems?

PLAN

TREATMENT/INTERVENTIONS

Y N Family planning method been individualized?

Y N Issuance of Supplies or Prescription?

EDUCATION/COUNSELING

Y N Specific to method?

CONSULTATION/REFERRAL

Y N N/A As needed?

FOLLOW-UP

Y N N/A Specific to method and as needed?

SERVICE

Y N Appropriate Level Personnel Providing Service?

MD PA RN ARNP OTHER (check one)

Y N Florida Professional License in Employee File?

Y N N/A Require Standard of Care Protocol?

Y N N/A Service Rendered by Credentialed Nurse?

Y N N/A Credentialling proof in provider's Emp File?

Y N Medically Necessary?

DOCUMENTATION

Y N Practitioner dated each record entry?

Y N Each Record Entry Legibly signed?

Y N Service recorded on appropriate standardized form?

ATTACHMENT B

ATTACHMENT B - Family Planning Waiver Budget Neutrality Worksheet

FEDERAL COSTS		1998	1999	2000	2001	2002	TOTAL
WITHOUT WAIVER							
BASIC FP SERVICES							
(All current eligibles)	Persons	67,036	67,036	67,036	67,036	67,036	
	Per Capita *	$ 213	$ 213	$ 213	$ 213	$ 213	
	Total	$ 14,298,779	$ 14,298,779	$ 14,298,779	$ 14,298,779	$ 14,298,779	$ 71,493,894
DELIVERIES - Target population X 27%	Persons **	3,240	3,240	3,240	3,240	3,240	
According to Lopez, pattern I users have an expected	Per Capita ***	$ 2,585	$ 2,555	$ 2,555	$ 2,555	$ 2,555	
fecundity of 27%.	Total	$ 8,377,017	$ 8,279,172	$ 8,279,172	$ 8,279,172	$ 8,279,172	$ 41,493,705
FIRST YEAR COSTS	Persons **	3,240	3,240	3,240	3,240	3,240	
	Per Capita ****	$ 1,756	$ 1,736	$ 1,736	$ 1,736	$ 1,736	
	Total	$ 5,690,457	$ 5,623,992	$ 5,623,992	$ 5,623,992	$ 5,623,992	
TOTAL WITHOUT-WAIVER COSTS		$ 28,366,253	$ 28,201,943	$ 28,201,943	$ 28,201,943	$ 28,201,943	$ 141,174,024
WITH WAIVER							
BASIC FP SERVICES	Persons	67,036	67,036	67,036	67,036	67,036	
	Per Capita *	$ 213	$ 213	$ 213	$ 213	$ 213	
	Total	$ 14,298,779	$ 14,298,779	$ 14,298,779	$ 14,298,779	$ 14,298,779	$ 71,493,894
DELIVERIES - #of deliveries as stated above X 21%. This is th	Persons ^	680	680	680	680	680	
reduced number of deliveries expected if family planning	Per Capita	$ 2,585	$ 2,555	$ 2,555	$ 2,555	$ 2,555	
services are made available and used by recipients (Lopez et al	Total	$ 1,759,174	$ 1,738,626	$ 1,738,626	$ 1,738,626	$ 1,738,626	$ 8,713,678
FIRST YEAR COSTS	Persons ^	680	680	680	680	680	
	Per Capita ****	$ 1,756	$ 1,736	$ 1,736	$ 1,736	$ 1,736	
	Total	$ 1,194,996	$ 1,181,038	$ 1,181,038	$ 1,181,038	$ 1,181,038	$ 5,919,149
EXPANDED	Persons ^^	3,250	9,125	11,000	11,000	11,000	
	Per Capita *	$ 213	$ 213	$ 213	$ 213	$ 213	
	Total	$ 693,225	$ 1,946,363	$ 2,346,300	$ 2,346,300	$ 2,346,300	$ 9,678,488
SYSTEM CHANGES		$ 50,000					$ 50,000
PUBLIC AWARENESS		$ 250,000					$ 250,000
EVALUATION		$ 29,400	$ 44,250	$ 17,150	$ 17,150	$ 30,200	$ 138,150
TOTAL WITH WAIVER COSTS		$ 18,275,573	$ 19,209,056	$ 5,283,114	$ 19,581,893	$ 17,248,643	$ 79,598,280
DIFFERENCE		$ 10,090,680	$ 8,992,887	$ 22,918,828	$ 8,620,050	$ 10,953,300	$ 61,575,744

*Average cost of FP ($237) x 90% FFP
**Target population (12,000) x 27%
***55.65% FFP x avg cost of prenatal & delivery ($4,646)
****55.65%FFP x newborn and 1st year costs ($3,156)
^3,240 x 21%, which is the number of preg. expected when % the births are averted with access to FP services.
^^Waiver population

ATTACHMENT C

PREGNANCIES AVERTED IN PUBLICLY-FUNDED FAMILY PLANNING USERS

(FLORIDA - 1994)

G.Lopez, M.D.
W.Westhoff, Ph.D.
K.Perrin, Ph.D.
R.Remmel, Ph.D.

The University of South Florida
College of Public Health
The Department of Community and Family Health

AUGUST, 1995

A. Introduction

Alma **Atta** in the 1970s, underscored the significant role that family planning has in the health of mothers and children. Surveys have also documented the importance of family life Limitation and healthful birth spacing'to improve the quality of life and to reduce maternal and infant mortality and morbidity. Beyond these benefits, there are monetary savings related to the number of births averted by family planning health services. Although saving money is not the primary goal, it is a factor of particular relevance for national and state health policy planners.

In the United States " publicly funded family planning services prevent an average of 1.2 million unintended pregnancies, including 509,000 unintended births and 516,000 abortions each year " (Donovan, 1995). The National Health Promotion and Disease Prevention Objectives for the year 2000, advocates that unintended pregnancies be reduced to 30% by the year 2000 (Department of Health and Human services, 1991). Unintended adolescent pregnancy is also a topic of popular concern, where frequently discussed solutions are oriented towards welfare reform, educational policies, and social support programs, but the potential of averting these pregnancies with family planning is not usually considered. " Although the evidence of the public health value of current family planning programs argue for their continuation and expansion, the gap between existing services and the theoretical benefit of all conceptions being intended is enormous " (Klerman, 1994)

E. Purpose

The purpose of this study was to document unintended pregnancies in Florida, and to estimate pregnancies and births averted in Florida's publicly funded family planning users in 1994 using different fecundity scenarios. The study also documented age-specific abortion bv groups of women's age, including young women. and ape-specific pregnancy rates for Florida in 1994.

C.Methods

Florida's Human and Rehabilitation Service (HRS) vital statistics reports and Centers for Disease Control (CDC) surveillance reports were reviewed. Raw aggregated statistics data of interval between births, as a general indication of spacing. was analyzed. Other terminations on the birth certificates of Florida residents were examined, particularly in young adolescents. **A** literature review confirmed that spontaneous miscarriage rate is influenced by age, antecedents, infections, and other pregnancy-related factors and characteristics of the population in question. **A** sporadic miscarriage rate of clinically recognized pregnancies in the general population has been quoted as 15% by several authors (Quemby, 1993). Therefore. in the calculations for determining the number of pregnancies and unintended births for Florida in 1994, this study used the number of reported live

births, the number of reported induced abortions, and an estimate of 15% of spontaneous fetal wastage. Standard usage rates and ratios were used with a definition when presented at specific, tables. The Pregnancy Risk Assessment Monitoring Survey (PRAMS), an ongoing weighted survey carried out in several states, measures the intendedness of pregnancy (n=2,059 in Florida) on mothers three months after birth. The Healthy Start Prenatal Survey (n=160,390 in Florida) also inquires about the intendedness of pregnancy. Percentages obtained from these surveys were used to estimate the percentage of unintended pregnancies and outcomes.

Since only mandated data collected by the state on induced abortions are limited to total numbers, durations of pregnancy, and reasons given, to obtain age-specific abortion data in Florida, survey data were collected from providers in six counties across the state. Abortion provider distribution is uneven in the 67 counties of the state; only nineteen of the counties reported more than one abortion to Vital Statistics in 1994. The uneven distribution implies a certain migration among regions, because of such migration, abortion rates and ratios at the level of each county may be distorted. For this study the sample was drawn by convenience from clinics in counties with the larger number of abortions. For the total number of abortions recorded in Florida by Vital Statistics in 1994, a sample size of 869 was calculated to be satisfactory for a 99% CI* By sampling one of 20 cases from 1994 at the clinics, a sample size of 1,280 cases was obtained from clinics in six Florida counties. These 1,280 cases are derived from 41,196 abortions recorded in the six counties. They represent a 56% of the total number of 73,394 abortions reported in Florida in the same year. Age distribution of cases sampled is somewhat uneven - as we believe is the population of Florida - with a young population of university students in Escambia county and counties like Pinellas or Sarasota with a much older population. A very simple questionnaire was applied to obtain main demographics and characteristics of cases sampled.

To obtain the number of unintended pregnancies and outcomes, after exploring different methodologies, the guidelines from Fitzgibbons Benefit Cost analysis of Family Planning in the State of Washington were followed (Fitzgibbons, 1994). Fecundity pregnancies and births averted in family planning users, used the Same guidelines, applying pregnancy failure rates for different methods (Trussell et al, 1990), and different patterns of behavior and expected fecundity as proposed by Forrest and Singh (Forrest and Singh, 1990). With data from HRS Bureau of Common Requirements, an estimate of the number of unintended births that could have occurred was done. A range of fecundity rate scenarios was used to arrive at the number of births averted among users of family planning services publicly funded.

D. General and Age-Specific Fertility Rates for the **1994 Florida Population**

Although the 1994 resident live birthrate of 13.7 per 1,000 population was at a low point since 1981, Florida's population increased 1.7% from 1993 to 1993. Residents live births to mothers increased to a new high of 35% of all births. Twenty-six per cent of white births and 65% of nonwhite births were to unwed mothers. Within the age group of 15- to

* See appendices for table on abortions by county and sample calculations.

19-years old, 78% of the births were to unwed mothers and 23% of the mothers had one or more previous live births. General fertility rate (live births per 1,000 women aged 15-44) for Florida in 1994 was 66.7, a decrease from 71.4 in 1990. (Florida Vital Statistics Annual report, 1994; MMWR, 1993). Table I illustrates birth and general fertility rates in Florida for five years. Table II illustrates age-specific fertility rates for Florida in in 1994.

Table I

Florida's birth and general **fertility** rates: 1990 - **1994**

Year	Resident live births	Birth rates [1]	General fertility rates[2]
1990	199,146	15.0	71.4
1991	193,717	14.6	69.0
1992	191,530	14.2	67.8
1993	192,453	14.1	67.7
1994	190,546	13.7	66.67

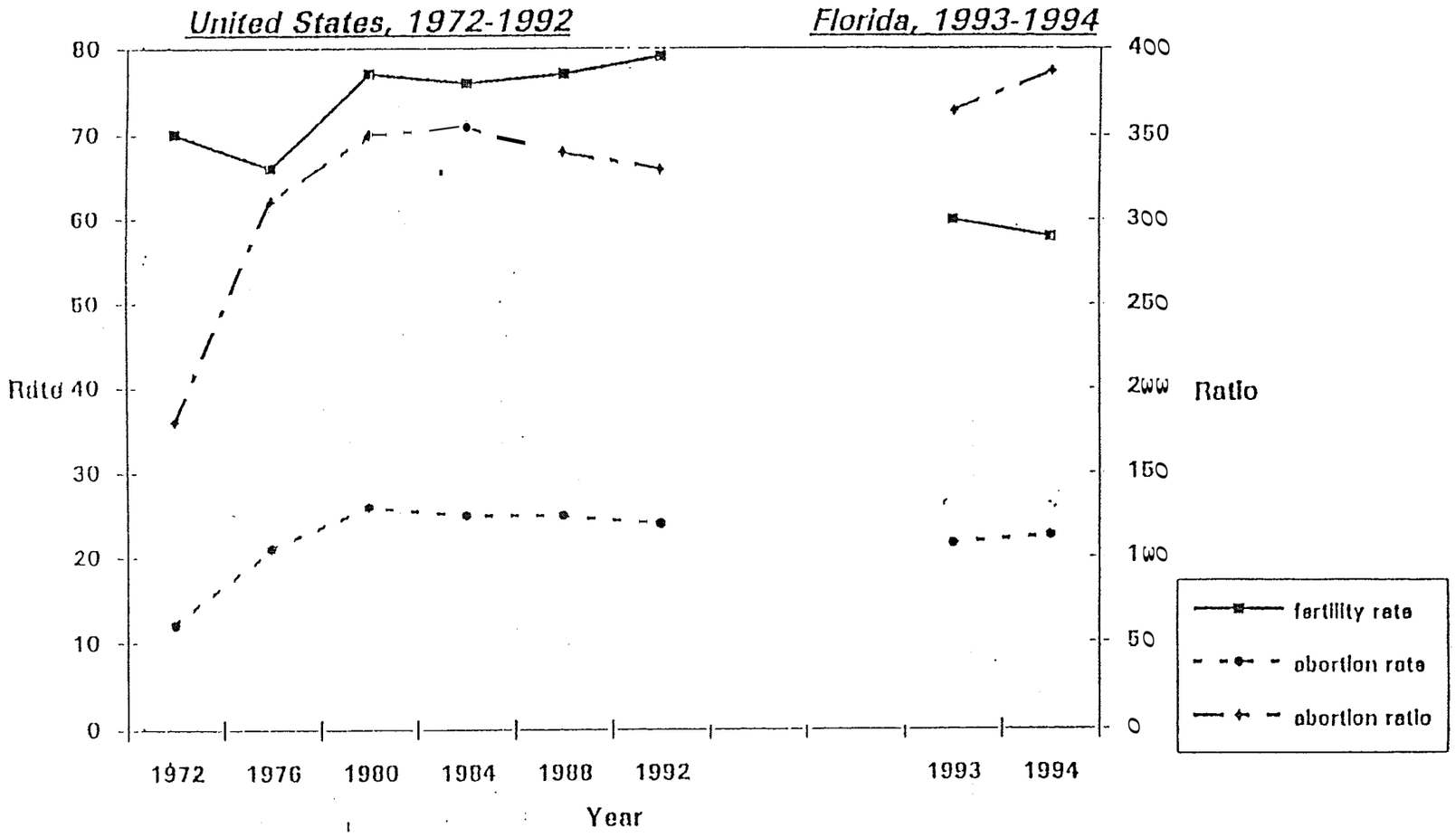
[1] live births per 1,000 population

[2] live births per 1,000 women 15 - 44 years of age

Source: Florida Vital Statistics Annual Report, 1994

Age of Mother	Births reported [1]	Female Population	Rates
15 to 19 [2]	25,165	391,196	66.8
20 to 24	48.540	414,367	117.14
25 to 29	51,017	458,090	111.37
to			
40 to 44	3,348	502,732	6.66
15 to **44** [3]	190,546	2,857,731	66,67

Fertility rate and abortion ratio, and rate, by year



County	Number of cases in Survey	Number of county abortions
Broward	203	8199
Dade	401	18180
Escambia	151	2264
Hillsborough	216	5541
Pinellas	201	4601
Sarasota	108	2011
TOTAL	1280	41196

Age	Survey abortions	%	Estimated abortions N.
13	7	0.5	367
14	16	1.3	954
15	40	3.1	2275
16	59	4.6	3376
17	62	4.8	3523
18	69	5.4	3963
19	71	5.5	4037
20 - 24	367	28.7	21064
25 - 29	234	18.2	13357
30 - 34	223	17.4	12771
35 - 39	100	7.7	5651
40 - 44	31	2.3	1688
> 44	1	0.1	73
TOTAL	1280	100	73394

The year by year stratification of adolescent girls shown in Table V corresponds to the interest in obtaining at least some gross estimates for these early years. Notwithstanding, we are aware that the number of cases in these narrow ranges is not large, probably, they should have been collapsed in the usual 15-19 year group including the below 15 years of age. From these figures it could be implied that 1 in 4 (25%) of abortions in Florida happens in females 19 years or less, or that 1 in 20 (4.9%) in a female 15 years or less. The 15-19 year abortion ratio was 675 and the rate for the Same age group was 43. Even excluding the data from the young university population served at Escambia county, with the remaining 1,129 cases still apparently an adequate sample, the abortion ratio for women 15-19 years of age was 524 and the rate was 34. In the U.S. the percentages of abortion in girls 15-19 years of age from 1988 to 1992 were: 5.3%, 24.2%, 22.4%, 21.0%, and 20.1% respectively; the U.S. abortion ratio in the same age group of 15-19 years of age was 515 in 1990 and 462 in 1991; the abortion rate was 30 in 1990 and 28 in 1991 (MMWR, 1993, 1995).

F. Unintended Pregnancy

It can be assumed that pregnancies are not always planned, intended, or wanted. As defined by the National Survey for Family Growth (NSFG) a pregnancy not wanted at the time of conception is an unintended pregnancy, with a distinction made between mistimed: those which occurred sooner than wanted, and unwanted: those that occurred when the woman did not want any more pregnancies at all. In addition it is critical to *make* the distinction between unwanted pregnancies and unwanted births. An unintended pregnancy can result in a much anticipated birth and cherished child.

According to a three-year study by the NSFG, 28% of births were mistimed and 12% were unwanted (MMWR, 1994). Lee (1995) reported that more than half of all pregnancies in the U.S. are unintended. Forrest (1990c) reports that 56% of the 6.4 million pregnancies in the U.S. in 1988 were unintended. In 1987, 69% of pregnancies to married women were unintended and 88% of pregnancies to never-married women were unintended. The rates of unintended pregnancies were higher in women 40-44 years of age (97%) as well as in the adolescent group. A high percentage of unintended pregnancies account for the high abortion rates in the U.S. (Forrest, 1990c). The reason underlying the unintended pregnancy does not differentially impact on the decision to abort. According to Forrest (1994), 51% of mistimed and 50% of unwanted pregnancies end in abortion.

The "wantedness" or "unwantedness" of a pregnancy is a subjective variable that depends not only on time and opportunity, but also on economic constraints, sociological. cultural and behavioral conditions. The research methodology, the wording! and the way in

which the specific questionnaire to inquire about intentions is constructed, play an important role in the type of response and results obtained. Even the concept of unintended pregnancy may be foreign or unknown to women with the fatalistic view that pregnancy and childbearing come from above and cannot be planned. The feelings of a mother can change in many ways over the course of pregnancy . The pregnancy outcomes may influence the accuracy of parental recall. Responses could be different if they are asked at the beginning, during, or at the end of the pregnancy. Ambivalent attitudes towards pregnancy or childbearing could exist, particularly at early or late age or under a specific circumstance. There is also the case of a wanted pregnancy that subsequently becomes unwanted because a genetic disease or defect is diagnosed in utero. Unintended pregnancy affects all levels of society and is not a problem of only adolescents or unmarried, poor, or minority women. Unplanned pregnancies are higher among poor and low-income women due to decrease accessibility to services and difficulties in the current and constant use of contraceptives.

In Florida, the 1993 Healthy *Start* Prenatal Survey inquired semi-prospectively at the initial pre-natal visit about the intendedness of the present pregnancy (n = 160,390). The results indicated that 38% of pregnancies were unintended, with 27.3% being mistimed and 10.7% being unwanted. Also in Florida, the Pregnancy risk Assessment and Monitoring survey (PRAMS) sent women a mail-phone questionnaire three months after giving birth. The results (n = 2,095) in 1993 of this on-going survey showed that 46% of newborns were unwanted or too early (See Tables VI and VII). The Prams survey also found that in mothers 15-19 years of age, 70.3% were unintended. Almost 60% of the babies born to households with annual income below $15,000 were unwanted, as were 60% of those born to women who had not finished high-school, and 69% of those born to women not married (Hopkins, 1994). Prams data also found that the rates of physical violence against women were significantly higher among unintended pregnancies.

Table VI

Timing and Wantedness of Pregnancy

Wanted sooner	Wanted iater	Wanted then	Wanted not at all
16.6 %	32 %	7.6 %	13.8 %

Source : PRAMS 1993 data, Epidemiology Program, Florida HRS.

Table VII

Intendedness of Pregnancy by Mother's Age, Educational Attainment, and Monthly Household Income

Mother's Age	% Unwanted	% Too Early	% Total Unintended
15 - 19	13.7%	56.6 %	70.3 %
20 - 29	13.4%	33.6%	47.0%
30 - 39	14.9%	19.2%	34.1%
Mother's Education			
Less than H.S.	19.1%	40.9 %	60.0%
High School	16.9%	31.0%	47.9 %
Some post H.S.	10.0%	31.6%	41.6%
College Graduate	3.6%	21.8%	**25.4%**
Household income per month			
< $ 650	25.9%	33.0%	58.95
$ 650 - 1300	16.7%	40.(%	57.6%
$1301 - 2100	13.9%	31.4%	45.3%
$2101 - 3300	2.4 %	27.9 %	30.3 %
> $ 3301	1.9%	16.4%	18.3%

Forrest (1990a) estimated that the use of contraception obtained from publicly-funded providers is responsible for preventing 1.3 **million** unintended births, 1.4 miliion induced abortions, and 400,000 miscarriages, for a total of 3.1 million unintended pregnancies prevented annually in the U.S., showing that the use of family planning services by low-income women reduced the probability of unintended pregnancy by 17% . More recently Forrest **and** Singh in different studies sugested that family **planning** reduces unintended pregnancy anywhere from 17% to 37.6% (Forrest and Singh, 1990)

G. Pregnancies, Births, Abortions, and Miscarriages (Florida 1994)

Following the guidelines from " Benefit-Cost Analysis of Family Planning in the State of Washington " (Fitzgibbons, 1994) and using the number of 1994 abortions recorded by Vital Statistics in Florida, a total of clinical pregnancies was calculated. There were 190,546 births and 73,394 abortions for a total of 263,940 recorded by Vital Statistics. Using the estimated figure of miscarriages of 15%, the total number of pregnancies in Florida for 1994 is estimated at 310,518. The estimated total clinical pregnancies is derived from the following equation: 190,546 + 73,394 + .15x = x.
Subtracting the number of births and abortions from the estimated total number of pregnancies is then possible to determine the estimated number of 46,578 miscarriages (See Table VIII) In women 15-44 years of age, 61% of pregnancies resulted in births, 24% in abortions, and 15% in miscarriages. For women 10-19 years of age, Vital Statistics registered 26,165 births. The same equation was applied with an estimate of the number of abortions (25.2%), since the number of abortions for this specific group was not available for Florida. The estimate was calculated from the age-specific abortion values of the survey data previously described: 26,165 + 18,495 + .15x = x.

Not Unintended Pregnancies Only

Table VIII
Pregnancies, Births, Abortions, and Miscarriages
Florida, 1994

	All women 10-44 years'		Women 10-19 years	
Birth Outcomes	Number	Per cent.	Number	Per cent.
Estimated Miscarriages	46,578	15%*	7,881	15%*
Abortions	73,394	24	18,495	35%
Estimated total Pregnancies	310,518	100%	52.541	100%

* For estimate of miscarriages a 15% was chosen, for other calculations see text

H. Unintended Pregnancies and Outcomes (Florida 1994)

Fitzgibbons (1994) and Forrest and Singh (1990c) state that: " national studies have indicated that 56% of U.S. pregnancies among women 10 - 44 years of age are unintended, and 81% of pregnancies in women 10 - 19 years of age are unintended ."

As previously discussed, the PRAMS survey data found 46% of unintended pregnancies, while the data from the Healthy Start Prenatal Survey report 38% of unintended pregnancies in Florida. Using the 46% from PRAMS (which is closer to the figure for the whole country) a number 142,838 unintended pregnancies are obtained. (See Table IX). As for women 10 - 19 years of age, using the 81% figure of unintended pregnancies from the literature that is probably closer to reality, 42,558 pregnancies were estimated.

	All women 10-44	Women 10-19
Estimated total number of Pregnancies	310,518	52,541
Percentage of Unintended Pregnancies	46% [1]	81% [2]
Estimated number of unintended pregnancies	142,838	42,558

2

See text for calculations.

Assuming that all abortions are the result of unintended pregnancies, the number of those unintended pregnancies that end in miscarriages and births are estimated using the actual number of abortions recorded by Vital Statistics for Florida. Therefore, estimating the total outcomes of the unintended pregnancies is possible. As shown in Table X, in women 10-44 years of age, the number of unintended pregnancies ending in miscarriages (using the same 15%) would be: 142,838 x 0.15 = 21,426. The number of unintended births may be then estimated by subtracting the number of abortions and miscarriages from the total: 142,838 - (21,426+73,394) = 48,022. Similar calculations for women 10-19 years of age would be: 42,558- (6,834 + 18,495) = 17,679.

Table X

Outcomes of Unintended Pregnancies in Florida, 1994

	All women 10-44 years		Women 10-19 years	
Estimated Miscarriages* Outcomes	21,426	15%	6,384	15%
Abortions	73,394	56%	18,495	43%
Estimated Births*	48,022	29%	17,679	42%
Estimated total Unintended Pregnancies	142,842	100%	42,558	100%

I. Fecundity and Births Averted Using Contraception (Florida 1994)

Demographic Iiterature often quote the Hutterites, a religious sect on the U.S. - Canadian border, **as** a group with highest natural fertility. Almost 90% of them carried a first pregnancy within a year of marriage (Trussell, 1990). The Oxford Family Planning Association showed that in parous women who stopped using contraceptive methods other than the pill, 89% gave birth within the next **21** months (Fitzgibbons, 1994). These percentages indicate a rather high fecundity. Nevertheless, in most of the family planning literature, women who use the services are felt to be self-selected as a population of good fecundity. **A** commonly expected number of pregnancies within the first year in a community of non-contraceptive-using fecund women has been frequently stated **as** 85% of women by several authors (Trussell, 1993). Women who want and use contraception are a population of sexually active fecund women because they already have had a pregnancy or are at **risk** of getting pregnant. Thus, the 85% seems to be adequate for some of the initial calculations.

Data fiom the HRS Family Planning Office in Florida and the Bureau of Common Reporting Requirements (BCRR) provided us with the number of family planning users on Title X-funded projects during 1994 by type of users and by county (See Table XI). The report did not include sterilization figures (Medicaid in Florida usually does not provide for sterilization). Not counting the 4,245 male users, there were a total of 186,556 users. Of these 177,396 were at or below the 150% poverty level. With the hypothetical fecundity of 85 % without contraception use the 186,556 users would have experienced 158,753 pregnancies. The 177,396 below the 150% poverty level would have experienced 150,787 pregnancies .

TABLE XI

Number of Family Planning Users by **Type of** Use **and Age (Florida *1994*)**

Type of Family Planning User	N of Users
1) Female at or below 100% poverty level	154.897
2) Female above 100% but not more than 150% of poverty level	22,499
3) Female above 150% poverty level	9,160
4) Male	**4,245**
6) Female adolescent users 15 - 19 years old (subset of Line 5)	45,725
7) Female under 15 years old	4,011

Source: BCRR Report N. 041390, Florida, 1994

This table applies only to projects that receive direct Title X funding.

On the other hand, it is well known that even with regular and adequate use of a contraceptive method a certain number of conceptions do occur, because of the expected failure rate of each specific method. Therefore, user failure pregnancies should be considered on calculating births averted in **a** group of women practicing contraception. HRS Family Planning Office in Florida also provided us with the total number of Title X-funded users (157,887) for 1994 by specific method used. Table XII illustrates the **157,887** users by method and the estimated number of probable 8,951 resulting failure pregnancies, calculated with method failure rates from Trussell (Trussell et **al** ., 1990).

Table XII

Estimated Failure Preenancies in Title X Family Planning **Users - Florida, 1994**

Contraceptive Method	No of Clients	Per cent Method failure rate [1] %	Pregnancies expected
Oral Pill	83,409	3	2,502
I. U. D.	1,774	3	53.2
Diaphragm	823	18	148
Condom/Spermicide	24,020	12	2,882
NFP	338	20	67.6
Sponge	326	28	91.2
Norplant	6.791	04	3.0
Depo-provera	36,765	. 3	110
No Method	3,641	85	3,094
Total number of clients:	157,687	**Pregnancies expected:**	8,951

[1] Trussell, Hatcher, Cates, Stewart, & Kost (1990) for per cent method failure rates.
Note: Number of clients from HRS Family Health (BCRR), Florida 1994.

Taking into consideration only the 157,887 users reported by the State, with a hypothetical fecundity of 85%, these women would have experienced 134,204 pregnancies. These were reduced to 8,951 pregnancies, thus avoiding 125,253 pregnancies. **A** drop in expected fecundity from 85 % to 5.6%.

The report from HRS shows that there were 45,725 users 15 - 19 years old and 4,011 under 15 years of age. Although this group deserves a different analysis because their fecundity and expected failure rate are higher, nevertheless, using the same calculations, with a fecundity of 85% they would have experienced 42,276 pregnancies (Since the breakdown data by method usage for this group was not available, the average failure rate from the general group was applied). The total contraceptive failure pregnancies experienced would have been 2,637 in this group under 19 years old. Again, a drop in expected fecundity from 85% to 5.9%.

III

Pattern	Expected fecundity	N of Pregnancies that would have resulted	N of pregnancies and per cent avoided *
high	85 %	134,202	125,253 (93%)
IV	78 %	123,152	114.201 (92%)
III	47 %	74.207	65,256 (88%)
II	33 %	52,103	43,152 (83 %)
I	27 %	42.629	33,678 (79 %)
low	17.6 %	27.776	18.827 (68 %)

Although the correlation is not completely exact, taking into consideration the previously estimated 310,518 prepancies in the State of Florida in 1994, one could say that with 85% expected fecundity there could have occurred 40% more pregnancies in the Same year; with 78% expected fecundity 37% more pregnancies ; with 47% expected fecundity **21%** more pregnancies; with 33% expected fecundity 14% more pregnancies; with **27%** expected fecundity 11% more pregnancies; and with 17.6% expected fecundity 6% more pregnancies.

As has been mentioned, the expected fecundity of 85%, although used in the literature, could be seen as the extreme **high** level, in the Same way that 17.6% could be seen as the extreme low. Table XIV presents the outcome of the estimated averted pregnancies with the fecundity of the other four different patterns mentioned and according to the distribution found in the general population of women 10 - 44 years of age (distribution shown before on Table X).

Table XIV

Outcome: (**Births,** Abortions,Miscarriages) of avoided unintended **p r** -es expected, accordin? to different patterns of use. Women 10 - **44** years of age (157,887 Title X users)

33678/157887

	SUGGESTED PATTERNS			
	I	II	III	IV
Unintended Pregnancies	33,678	43,151	65,256	114,201
Births (29%)	9,767	12,515	18,925	33,119
Abortions(56%)	18,860	24,165	36,543	63,952
Miscarriages (15%)	5,051	6,472	9,788	17,130

The figures from Pattern IV which represent women using no prescription methods **(78%** fecundity **)** averting 114,201 pregnancies, or perhaps those from Pattern III, which describes women's fecundity when they arrive at the family planning clinic for the first time (47% fecundity) averting 65,256 pregnancies, are probably more within the reality of the group of Title X women users in Florida.

The group of users under 19 years of age deserves a different analysis because their fecundity and the expected pregnancy failure rate is probably higher. Nevertheles, the outcome of the 42,276 averted unintended pregnancies mentioned before and according to the distribution found in this same group in the general population (as shown before on Table X) with their 85% fecundity would represent 17,756 births, 18,179 abortions, and 6,3441 miscarriages avoided.

Summary and Conclusion

Unintended prepancies in Florida **as** in the U.S. are **high.** The primary prevention strategy for achieving major reductions of unwanted pregnancies in most people should consider an increase in contraceptive use. Florida needs a more complete and better registration of induced abortion users and their characteristics for its analysis. Based on **a** sample survey of some of the Florida counties with higher abortion figures, abortion rates and ratios are presented with estimated age-specific figures for the State. Estimated number of unintended pregnancies in women 10-44, and 10-19 years of age are presented . Using different scenarios with different figures of expected fecundity and patterns, the number of births averted was estimated in the gorup of women users of Title X family planning clinics in Florida in 1994. The percentage of pregnancies averted ranges from 68% to 93% according to different expected fecundities. In Pattern III based on the fecundity of new family planning clients before accessing family plannning clinic care (47% expected fecundity), 65,256 pregnancies would have been averted . In Pattern IV based on women using no formal contraceptive method (78% expected fecundity), 114,201 pregnancies would have been averted. Outcomes of unintended pregnancies for different patterns are also presented . The number of pregnancies and births averted according to different scenarios, could constitute the basis for more detailed cost-data utilization and analysis ofbenefits in contraceptive users in the state .

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Appendices

Sample size estimation

Population: Total number of abortions recorded in Florida, 1994.
73,394

Expected Frequency: 30.00%

Worst Acceptable: 26.00%

Confidence Level	Sample **Size**
80 %	215
90 %	353
95 %	501
99%	**861**
99.9 %	1,394
99.99 %	1,934

Table 1. Sample **Size** from Epi-Info (Statcalc)[1]

[1]A test to determine the sample size of the study by a power analysis was based on the following information: 1) accepted conventions for the parameters of the test was an alpha = 0.01, which produces a **beta** of 0.96 [1 - **beta** = 4 alpha], and **2)** a moderate effect size (i.e., 0.30) **was** anticipated **since** no assumption could be extrapolated from similar studies in the literature. **Using** these numbers and entering the data into Epi-Info (Statcalc) a sample **size** of 861 at a 99% **C.I.** was **calculated** to be satisfactory for the study. Table 1 shows the confidence levels and sample **sizes** calculated by Epi-info.

The sample ***size*** normally depends on several factors: 1) the direct and indirect cost of the **study** and the **size** of the budget, **2)** The number of subgroups and number of variables in the study, **3)** the **desired** level of statistical power desired, and ***4)*** the amount of attrition. ***Several*** limitations should be noted here **regarding** the sample **size**: 1) the sample size was based ***on*** the number of abortions reported in the state, rather than for each of the six counties where the **data** were collected, **2)** although subgroups by age are reported in this study they were not factored into estimating the sample size, and 3) Statcalc is a simple and rather unsophisticated method of calculating an estimated sample **size.**

Table 1

Reported Induced Abortion, by County, Florida, 1990-1994

County	1990	1991	1992	1993	1994
Florida	66073	71254	69285	70069	73394
Alachua	3070	2943	2708	2684	2473
Baker	0	0	0	0	0
Bay	28	57	96	82	65
Bradford	0	0	0	0	0
Brevard	1886	1799	1325	1300	1418
Broward	8398	7982	7452	7919	8199
Calhoun	0	0	0	0	0
Charlotte	0	1	1	228	174
Citrus	0	0	0	0	0
Clay	0	0	0	0	0
Collier	382	302	152	271	314
Columbia	0	0	0	0	0
Dade	10720	13934	14344	18046	18180
DeSoto	0	0	0	1	0
Dixie	0	0	0	0	0
Duval	5820	6079	6012	5973	5451
Escambia	2002	2080	1935	2116	2664
Flagler	0	0	0	0	0
Franklin	0	0	0	0	0
Gadsden	0	0	0	0	0
Gilchrist	0	0	0	0	0
Glades	0	0	0	0	0
Gulf	0	0	0	0	0
Hamilton	0	0	0	0	0
Hardee	0	0	0	0	0
Hendry	0	0	0	0	0
Hernando	0	0	0	0	0
Highlands	0	0	0	0	0
Hillsborough	5425	5225	5362	5524	5541
Holmes	0	0	0	0	0
Indian River	0	0	0	0	0
Jackson	0	2	3	1	1

Jefferson	0	0	0	0	0
Lafayette	0	0	0	0	0
Lake	0	0	0	0	0
Lee	1874	2131	1937	1725	1748
Leon	4128	3220	2858	3063	3018
Levy	0	0	0	0	0
Liberty	0	0	0	0	0
Madison	0	0	0	0	0
Manatee	0	0	0	0	1
Marion	0	0	0	2	0
Martin	0	0	0	0	0
Monroe	2	0	5	1	1
Nassau	0	0	0	0	0
Okaloosa	920	805	848	515	0
Okeechobee	0	0	0	0	0
Orange	6045	7365	6690	4447	7063
Osceola	0	0	0	0	0
Palm Beach	4277	4219	4587	4860	5934
Pasco	0	0	0	0	0
Pinellas	5769	5562	5239	5026	4601
Polk	1513	1554	1576	1466	1459
Putnam	0	0	0	0	0
Saint Johns	0	0	0	0	0
Saint Lucie	863	973	932	1069	509
Santa Rosa	0	0	0	0	1
Sarasota	2441	2236	2067	1934	2011
Seminole	320	389	535	579	0
Sumter	0	0	0	0	0
Suwannee	0	0	0	0	0
Taylor	0	0	0	0	0
Union	0	0	0	0	0
Volusia	190	2396	2621	1237	2568
Wakulla	0	0	0	0	0
Walton	0	0	0	0	0
Washington	0	0	0	0	0

Source: Florida Vital Statistics, 1994

ATTACHMENT D

ATTACHMENT D - Family Planning Waiver Budget neutrality Worksheet

FEDERAL COSTS		1998	1999	2000	2001	2002	TOTAL
WITHOUT WAIVER							
BASIC FP SERVICES							
(All current eligibles)	Persons	67,036	67,036	67,036	67,036	67,036	
	Per Capita *	$ 213	$ 213	$ 213	$ 213	$ 213	
	Total	$ 14,298,779	$ 14,298,779	$ 14,298,779	$ 14,298,779	$ 14,298,779	$ 71,493,894
DELIVERIES	Persons **	776	776	776	776	776	
Target Population X 6.47%	Per Capita ***	$ 2,585	$ 2,555	$ 2,555	$ 2,555	$ 2,555	
	Total	$ 2,007,381	$ 1,983,935	$ 1,983,935	$ 1,983,935	$ 1,983,935	$ 9,943,121
FIRST YEAR COSTS	Persons **	776	776	776	776	776	
	Per Capita ****	$ 1,756	$ 1,736	$ 1,736	$ 1,736	$ 1,736	
	Total	$ 1,363,602	$ 1,347,675	$ 1,347,675	$ 1,347,675	$ 1,347,675	
TOTAL WITHOUT-WAIVER COSTS		$ 17,669,762	$ 17,630,389	$ 17,630,389	$ 17,630,389	$ 17,630,389	$ 88,191,318
WITH WAIVER							
BASIC FP SERVICES	Persons	67,036	67,036	67,036	67,036	67,036	
	Per Capita *	$ 213	$ 213	$ 213	$ 213	$ 213	
	Total	$ 14,298,779	$ 14,298,779	$ 14,298,779	$ 14,298,779	$ 14,298,779	$ 71,493,894
DELIVERIES - #deliveries /15. According to a study by Tompkins, 1986,	Persons ^	52	52	52	52	52	
1 pregnancy is averted for every 15 women who seek family planning servic	Per Capita ***	$ 2,585	$ 2,555	$ 2,555	$ 2,555	$ 2,555	
	Total	$ 133,825	$ 132,262	$ 132,262	$ 132,262	$ 132,262	$ 662,875
FIRST YEAR COSTS	Persons ^	52	52	52	52	52	
	Per Capita ****	$ 1,756	$ 1,736	$ 1,736	$ 1,736	$ 1,736	
	Total	$ 90,907	$ 89,845	$ 89,845	$ 89,845	$ 89,845	$ 450,287
EXPANDED FP	Persons ^^	3,250	9,125	11,000	11,000	11,000	
	Per Capita *	$ 213	$ 213	$ 213	$ 213	$ 213	
	Total	$ 693,225	$ 1,946,363	$ 2,346,300	$ 2,346,300	$ 2,346,300	$ 9,678,488
SYSTEM CHANGES		$ 50,000					$ 50,000
PUBLIC AWARENESS		$ 250,000					$ 250,000
EVALUATION		$ 29,400	$ 44,250	$ 17,150	$ 17,150	$ 30,200	$ 138,150
TOTAL WITH WAIVER COSTS		$ 15,546,136	$ 16,511,499	$ 16,884,336	$ 16,884,336	$ 14,551,086	$ 80,377,393
DIFFERENCE		$ 2,123,626	$ 1,118,890	$ 746,053	$ 746,053	$ 3,079,303	$ 7,813,925

*Average cost of FP ($237) x 90% FFP
**Target population (12,000) x 6.47%
***55.65% FFP x avg cost of prenatal & delivery ($4,646)
****55.65%FFP x newborn and 1st year costs ($3,156)
^3,240/ 15. According to Tompkins, 1 birth is averted for every 15 women that seek family planning services.
^^Waiver population